Arkansas Legislative Task Force on Substance Abuse Treatment Services

Final Report and Recommendations

Submitted by the
Arkansas Legislative Task Force on
Substance Abuse Treatment Services

September 30, 2010

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TASK FORCE MEMBERS

Legislative Members

Senator Bill Pritchard, Chairman

Senator Kim Hendren

Senator Gene Jeffress

Senator Joyce Elliott

Representative Eddie Cooper

Representative Frank Glidewell

Representative Kathy Webb

Representative Tim Summers

Non-Legislative Members

Casey Bright
Quapaw House, Inc.
Hot Springs

Diane Bynum
Horizon Adolescent Treatment Program
Forth Smith

Saima Chauhan
AAADAC
Rogers

Jim Clark
Addiction Treatment Services
Health Resources of Arkansas
Searcy

Mike Clark
Crowley's Ridge Development Council
Northeast AR Regional Recovery Center
Jonesboro

Carolyn Dresler
AR Department of Health
Tobacco Prevention Cessation
Little Rock

Fran Flener
Dept. of Human Services
Division of Behavioral Health
Little Rock

Fred Garcia
Decision Point, Inc.
Bentonville

Joe M. Hill
Dept. of Human Services
Division of Behavioral Health
Little Rock

Anita Hudson-Meadows
Gateway House, Inc.
Fort Smith

Gary Morgan
AR Board of Alcoholism & Drug Abuse Counselors
Marshall

Rev. William H. Robinson
Better Community Developers
Little Rock

Carol Roddy
Administrative Office of the Courts
Little Rock

EXECUTIVE SUMMARY

The Legislative Task Force on Substance Abuse Treatment Services was convened to evaluate substance abuse treatment services in Arkansas. Act 1457 of 2003 includes five specific actions the task force was commissioned to do:

- Identify statewide services costs to secure more stable revenue sources
- Utilize cost benefits analysis for studying outcomes
- Establish a strategic development and implementation program
- Identify the needs in the current system of delivery
- Review interagency referral and continuity of care trends

According to the Substance Abuse and Mental Health Services Administration (2008), only six percent (6%) of persons in need of substance abuse treatment in Arkansas receive treatment. The consequences of untreated alcohol, tobacco and drug abuse comprise the single greatest drain on Arkansas' state budgets.

Although state agencies and the network of publicly-funded community-based providers are in an excellent position to serve additional persons needing substance abuse treatment, there continues to be a lack of coordinated efforts to pull funding streams together to maximize their impact on the issue. During austere economic times, the state must learn how to work smarter with those funds currently available while waiting for the legislative will to increase funding for treatment services in the state. Where there are opportunities to better utilize funding streams to maximize treatment coverage, those avenues must be pursued.

Continued efforts must be made to promote the message that addiction is a chronic illness, akin to chronic diseases such as diabetes, asthma or hypertension. There is no "cure" for a chronic disease. Instead, those afflicted must work to maintain the disease through varying levels of treatment to avoid relapse. The state must learn that effective substance abuse treatment requires several levels of care, from intensive residential treatment to transitional sober-living settings. Money invested wisely in the less expensive recovery support services will be money well spent on relapse prevention.

RECOMMENDATION SUMMARY

The Task Force recommends the following actions to enhance and expand effective substance abuse treatment.

Seek new funding resources to expand treatment capacity and fund Medicaid. Support drug Courts:

- Fund Medicaid coverage for adolescents, pregnant and postpartum women from the tobacco tax proceeds of the increase enacted in 2009.
- Continue expansion of adult drug court programs, juvenile drug courts, DWI courts, veterans treatment courts and other therapeutic criminal justice diversion programs that mandate treatment for program participants and have proven successful in increasing public safety, reducing prison crowding, and restoring lives of addicted Arkansans.
- Begin assessing the number of eligible enrollees for Medicaid assisted treatment under Health Care Reform (HCR) and those that will be eligible for government subsidized treatment under HCR.
- Encourage state agencies to secure additional treatment funding through collaborative, coordinated approaches to federal grants, block grants, categorical funding, state appropriations and additional revenue sources.

Continue Accountability and Quality Improvements:

- The Division of Behavioral Health Services shall develop, with treatment providers, a set of performance measures using evidence-based practices.
- The Division of Behavioral Health Services shall collect and report data to treatment providers on the set of performance measures.
- The Division of Behavioral Health Services shall develop, with treatment providers, a set of state performance standards for treatment based on data collected during the first 12 months for the performance measures.

Support a Treatment Continuum of Care:

- Develop recovery support services that provide real assistance for families and individuals seeking treatment services regardless of the point of contact where the seeker enters the care continuum.

- Recognize that sustaining abstinence and relapse prevention activities post-acute treatment discharge are important factors in achieving long term recovery, and increase resources to assist with safe and appropriate housing for persons in transition from treatment to long-term recovery.

Revise Involuntary Commitment Laws Related to Substance Abuse:

- Current commitment laws fail to utilize the best resources for initial assessment and evaluation for appropriate and least restrictive treatment settings. These should be updated.

Support Advocacy:

- Continue a statewide advocacy and communications campaign to inform policymakers and the public that substance abuse is a chronic health problem that is treatable. Reinforce with data driven treatment information on utilization of evidence-based practices as an effective return on investment.

Background Information that Informs our Recommendations

Burden Spending of Substance Abuse

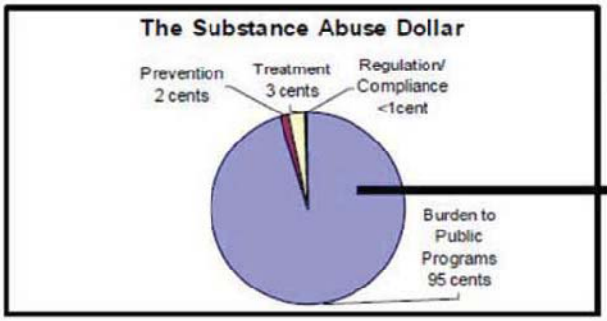
In the 2005 comprehensive study conducted by the National Center on Addiction and Substance Abuse at Columbia University, the total expenditures on substance abuse by the state were calculated to be $888 million, the third largest portion of the annual state budget, behind only elementary and secondary education and higher education. Only a small percentage of this amount is spent on treatment. For each dollar spent on the burden substance abuse creates on public programs, only two cents is spent on prevention activities and only slightly more, three cents, on treatment programs. Regulations and compliance expenditures are less than a penny.

These calculations exclude state Medicaid expenditures that are also driven by the burden of health issues presented by substance abusers. The following table shows the break-down by category of burden spending in the state. This table is currently being updated under the Closing the Addiction Treatment Gap (CATG) grant project with additional resources provided by the Arkansas Center for Health Improvement (ACHI). The project hopes to complete the update by January 2011.

Arkansas

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$845,655.6***		***8.5***	***$300.85***
Justice	**447,941.6**	**359,717.5**		**3.6**	**127.97**
Adult Corrections	296,924.1	237,674.3	80.0		
Juvenile Justice	45,747.8	35,920.7	78.5		
Judiciary	105,269.7	86,122.5	81.8		
Education (Elementary/Secondary)	**2,327,569.2**	**263,992.9**	**11.3**	**2.6**	**93.92**
Health	**522,228.8**	**133,199.6**	**25.5**	**1.3**	**47.39**
Child/Family Assistance	**71,971.0**	**40,808.1**		**0.4**	**14.52**
Child Welfare	48,931.8	35,658.7	72.9		
Income Assistance	23,039.1	5,149.4	22.4		
Mental Health/Developmental Disabilities	**113,880.6**	**40,213.2**		**0.4**	**14.31**
Mental Health	67,391.2	36,669.1	54.4		
Developmental Disabilities	46,489.3	3,544.0	7.6		
Public Safety	**33,506.0**	**5,972.9**	**17.8**	**0.1**	**2.12**
State Workforce	**507,299.2**	**1,751.5**	**0.3**	**0.0**	**0.62**
Regulation/Compliance	***3,626.4***	***3,626.4***	***100.0***	***0.0***	***1.29***
Licensing and Control	3,126.4	3,126.4			
Collection of Taxes	500.0	500.0			
Prevention, Treatment and Research	***38,242.8***	***38,242.8***	***100.0***	***0.4***	***13.61***
Prevention	9,774.3	9,774.3			
Treatment	17,072.7	17,072.7			
Research	NA	NA			
Unspecified	11,395.7	11,395.7			
Total		***$887,524.8***		***8.9***	***$315.75***



Total State Budget	$9,982 M
• Elementary and Secondary Education	$2,328 M
• Substance Abuse and Addiction	$888 M
• Medicaid	$771 M
• Higher Education	$2,129 M
• Transportation	$586 M
Population	2.8 M

Tobacco and alcohol tax revenue total $191,239,000; $68.04 per capita.

* Numbers may not add due to rounding.

Substance abuse and addiction negatively impact individuals, families, communities and state agencies. During recent years, new research has shown that treatment can be effective. However, like any other chronic disease, treatment is not a cure. Longer time periods of intensive treatment are more appropriate for those who have suffered damage to their brain from the ingestion of certain substances. The course of "drying out" in a detoxification program and then being released back to the community has only resulted in the revolving door of treatment for many addicts. Treatment requires constant monitoring, random drug testing, assistance with life-skills, housing, job placement, etc. Many things non-addicts are able to do for themselves; addicts have either lost or never had the ability to do. It is not uncommon to frequently find second and third generation abusers in need of drug treatment. For these persons, a life using drugs and getting high has become their "normal." Obviously, a 30 day course of treatment will have little effect, if any, after a life-time of drug abuse.

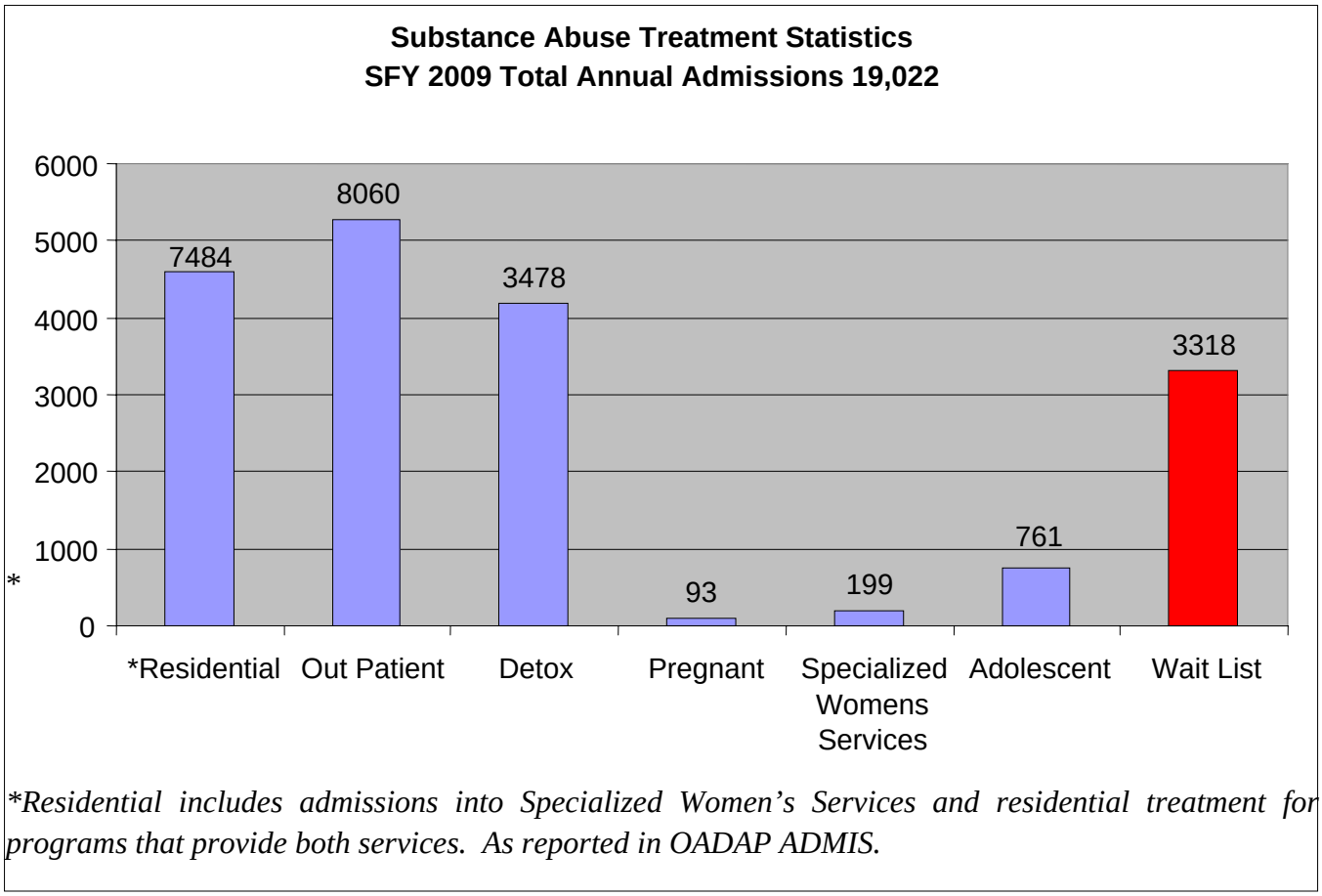
Treatment providers must also develop sufficient assessment tools to differentiate between "addict" and mere "abusers" to design and deliver the most appropriate, cost effective treatment program. The continued treatment of everyone like a "nail in need of a hammer" should give way to an individualized path for treatment seekers. Abusers of alcohol or drugs are persons who continue to be able to control their intake of the substance. An addict or alcoholic has lost that control and will need longer, extended, step-down treatment. But abusers should be treated with stiffer sanctions and more negative consequences to move them off their path to addiction. The treatment community needs to develop these different paths to provide the most appropriate treatment at the least cost to the state.

Until now, the federal government has been the major funder addressing the public health problem of alcohol and drug abuse. Arkansas' 2010 Substance Abuse Prevention and Treatment (SAPT) block grant provides over 73% of all public funding for alcohol and drug abuse treatment with a current allocation below the level received in SFY 2005.

- **State funding for substance abuse treatment remains at the same level since 1995 (15 years) although additional resources were enacted during the 2009 legislative session. The state falls far short of meeting the treatment needs.**

Despite these dedicated resources, funding levels for treatment continue to fall short in the state. As noted in the 2008 report of this Committee, only 1 out of 20 people needing treatment are able to obtain it. Statewide, on a monthly basis, over 117 individuals referred for treatment from private citizens, faith-based organizations, criminal justice and child welfare systems, and our courts, are on waiting lists seeking public treatment. The publicly-funded treatment system is straining to address the needs of citizens who cannot pay for treatment. A recently released report on Poverty in America showed that 1 in 6 Arkansans live in poverty. Of particular concern is the chronic long-term shortage in family treatment capacity for adolescents, pregnant women, and women with children.

Treatment *delayed* is often treatment *denied.* Research has shown that the sooner treatment is made available to the person seeking it, the greater likelihood of having better treatment outcomes. During state fiscal year (SFY) 2010, over 3,300 Arkansans were placed on a waiting list while seeking publicly-funded treatment. As this report will explore later, this frequently results in a "gaming" of the system of publicly-funded treatment by over-utilization of court-ordered involuntary commitment procedures, adding additional stress and strain to the judicial system along with the providers of treatment.



**Residential includes admissions into Specialized Women's Services and residential treatment for programs that provide both services. As reported in OADAP ADMIS.*

If, during the current economic climate, it is impractical to seek a large increase (the 2008 report of this Committee sought a $16 million increase), then measures should begin to develop a plan to fully fund the state portion of Medicaid funding that will be available under the federal health care reform legislation to fully maximize federal resources to treat substance abusing populations. Under the current match rate, $16 million in services can be provided with just $4 million in state match dollars, assuming under health care reform the bulk of this population would be below the 133% federal poverty level (FPL). Community providers could easily expand the current 339 residential treatment slots to 559 while also increasing outpatient treatment capacity. Since the federal program does not become fully operational until 2014, now is the opportune time to begin this planning process.

The Committee also seeks to fund the Medicaid coverage for adolescents, pregnant and postpartum women using the rightful portion of the tobacco tax enacted for this purpose during the 2009 legislative session. This program is the only program in the package considered for the tax that has not been funded to date. This is also, ironically, the only program for which the state can draw down three federal dollars for every dollar of state revenue spent.

The state now has 41 adult drug court programs, 10 juvenile drug courts, two DWI courts and two veterans treatment courts. These programs, and other therapeutic-based criminal justice diversions, should be fully supported and expansion should be encouraged. In FY2009, the adult drug court program diverted over 1,900 persons from incarceration in the prison. At the rate of $45.96 in savings per day (average daily costs of state prison incarceration minus daily drug court costs), this program saved the state **$87,324 per day or an annual savings to the state of nearly $32 million**.

Implementation of Evidence-based Practices

Much has been done during the interim towards the complete utilization of evidence-based practices in the treatment field. Office of Alcohol and Drug Abuse Prevention (OADAP) will include in its grants with providers for the next funding cycle the requirement that only evidence-based treatment regimes be utilized. In addition, a set of performance measures are being developed upon which to begin collecting data from each provider. This data will be reported back to providers on a quarterly basis and form the template for providers to develop, with technical assistance from the state, improvement plans for those measures that appear less than ideal. Finally, after a year of analysis and working with the new data set, OADAP will be in a position to work with providers to set some state treatment standards for which all providers should comply to continue funding under the substance abuse grants.

The state's treatment provider network has fully embraced the transition to evidence-based practices and the need for national accreditation as treatment providers by such organizations as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Since 2008, the Arkansas Division of Behavioral Health Services (DBHS) has worked with other state agencies serving addicted persons to determine common, shared outcomes targets. These have been recently incorporated into the upcoming contract renewals with treatment providers and training is being conducted on reporting this data to DBHS.

Arkansas has implemented the ten National Outcomes Measures (NOMs) identified by Substance Abuse and Mental Health Services Administration (SAMHSA) as reflecting real-life outcomes for people trying to attain and sustain recovery: abstinence; employment/education; crime and criminal justice; stability in housing; access/capacity; retention; social connectedness; perception of care; cost effectiveness; and use of evidence-based practices. These provide a strong base for development of interagency outcomes that could be adjusted to include, for example, child welfare issues. DBHS should continue its work with treatment providers to establish a set of state standards based on the performance

measures. Once established, in the future treatment funding contracts will require outcome measures that will financially reward or penalize agencies based on their outcomes.

In order to advance the message and ongoing system improvements, the Committee will recommend that the Alcohol and Drug Abuse Coordinating Council, in concert with DBHS/OADAP, advocate for state funding for substance treatment services. This Council, which is chaired by the State Drug Director, includes state agency leaders/decision-makers, providers, consumers, and community-based grass-roots coalitions are charged with coordinating alcohol and other drug services of state departments, the criminal justice system, law enforcement, the legislature, and treatment/prevention programs.

Current System Lacks Over-all Coordination

Another strategy in the absence of an immediate increase in funding is to blend and coordinate funds from multiple agencies to increase addiction treatment for populations that are non-served or underserved. The state must learn how to stretch scarce resources by appropriate utilization of services. Not every person seeking treatment requires residential care. New techniques of intensive out-patient care have proven to be successful and often less disruptive on substance abusers' lives. For many, the only normalcy they have left is a job. Allowing them to enter the treatment arena in such a way that supports their continued employment while providing sufficient care could result in a faster return to sobriety. Multiple agencies serving addicted clients should develop shared strategies for funding and delivering an array of treatment services. The Committee believes a subcommittee under the leadership of the State Drug Director is the appropriate means to begin this process.

Long-Term Sobriety Requires a Treatment Continuum of Care, including Sober Living Arrangements

Along with the knowledge that treatment does not provide a "cure" comes the need to establish a continuum of care to assist addicts and alcoholics in managing their disease. Unlike the diabetic, asthma patient, or person suffering from hypertension, the substance abusers' brain has been so adversely affected by abuse that many in recovery state that they stopped "growing" the day they started using (drugs or alcohol). For many, this stifling of growth results in someone unable to cope with "daily living skills" much like a person who suffers from dementia conditions in later life. A treatment program that provides meaningful assistance in navigating through housing, employment, medical care, child care, transportation, education, clothing and nutrition, will be needed initially by some to maintain their long-term recovery.

In the recent report, Addiction Treatment and Long-Term Recovery in Arkansas: Just Say Yes! author Paul Kelly of Arkansas Advocates for Children and Families concluded that while the state is doing a good job at outreach and retention in treatment, the program is less successful in the areas of securing housing, jobs and social support networks for those leaving treatment.

Arkansas has an abundance of weekly peer-support group meetings. In a survey conducted by the State Drug Director's office in 2009, there were a total of 1,258 meetings held throughout the state. Establishing linkages between these support systems and more formal programs of care can help provide the "management system" for those in life-long recovery. Just as assistance is sought to help those afflicted with other chronic illnesses, we must abandon the idea of punishing addicts and alcoholics and start providing the necessary structure for them to manage their disease. The ideal continuum of care system would allow entry at any point of choice by the substance abuser with sufficient support to prod the person into a more structured setting or to fewer services as they progress.

Key to understanding the need for a continuum of care is the knowledge that substance abuse is a chronic health condition, much like hypertension, diabetes or asthma. While we support the medical community in providing an array of after-care and rehabilitative services to assist persons with chronic conditions in managing their health, we, as a society as a whole, do very little to support those afflicted with substance abuse to manage their continued health needs. We have, for too long believed that treatment is the cure. We now know that it is not. Just as persons who fail to manage their high blood pressure, sugar intake or asthma can become extremely ill, so can substance abusers who fail to stay sober and relapse. However, we have chosen to openly punish people who relapse while in recovery, although we do not similarly punish those who do not take their medications or follow their diet and exercise regimes for their chronic conditions. We must do better to assist addicts and alcoholics in transitioning back to the community as fully functional, tax-paying citizens.

A large part of maintenance of sobriety is safe, affordable housing in a sober living situation, perhaps even with peer-support available on site. The Committee heard presentations from Oxford House, Inc., a transitional housing program that has been developed during the past 19 years in several states. There are currently three Oxford Houses in Arkansas communities. Oxford Houses are sober living arrangements in residential houses that are peer governed and operated. A typical Oxford House will provide shelter for up to seven or eight same-sex adults. Persons are permitted to remain in a house for up to two years under the program. Household expenses and chores are divided and shared equally by the residents of the house. Residents determine who is granted permission to join the house when a vacancy occurs. Oxford Houses have a zero tolerance for substance abuse, including alcohol. A resident who is proven guilty of using is immediately put out of the house to maintain the sobriety of the other residents. The residence is privately owned. The persons occupying the house pay rent as part of the household expenses. For the program to become established and sustained, it seems to only need one or two outreach workers and support staff to channel new residents to the prospective houses and assure compliance with the national standards of operation. OADAP should explore partnering with a non-profit entity to implement Oxford Houses in the state.

Involuntary Commitment Laws Related to Substance Abuse

The Committee heard testimony concerning the need to assist local judges and prosecutors in appropriately screening persons into treatment due to a condition of being gravely disabled, homicidal, or suicidal, the standard for involuntary commitment due to substance abuse. The unavailability of publicly-funded treatment slots with providers has resulted in family members streaming to the court house to seek court-ordered treatment. In some areas of the state, persons who are screened for routine entry into a treatment program during the morning and are told they will be placed on the "waiting list" are delivered to the door of the treatment provider by late afternoon with an order of commitment that usually waives all payment of fees in violation of existing statutes. Many of such persons, when tested, have no alcohol or other drugs in their system at the time of commitment. Their 'involuntary commitment' to the facility moves them to the front of the line where, before, they would have been behind pregnant women and HIV positive substance abusers on the waiting list in compliance with federal requirements for this funding. This is the "gaming" of the treatment system that is occurring repeatedly as more persons seek substance abuse treatment.

There are only two lock-up facilities in the state that handle secure involuntary commitments for substance abuse. The rest of the providers are left accepting these court-ordered patients who then are not required to comply with the terms of the treatment program, who also frequently exhibit inappropriate behavior and destroy the property of the provider, while placing other residents at substantial safety risks.

For this reason, the Committee is seeking legislation that would direct all involuntary substance abuse commitments to appear before a designated court judge (preferably the judge assigned the drug court docket in the county, if available) in the judicial district where the commitment is sought. The Committee is further asking that a credentialed addiction professional (see list provided in Appendix E) conduct an initial assessment prior to the entry of any order directing the person to a treatment facility. Amend current civil commitment law to allow for a clinical assessment of the person's treatment needs. By utilizing the expertise of an addiction professional, the person will be assured that an appropriate placement will be made in the least restrictive treatment environment.

TASK FORCE RECOMMENDATIONS

The time is right for Arkansas to coordinate resources to enhance and expand effective substance abuse treatment. According to a May 2009 survey, 92% of Arkansans believe that drug addiction is a problem, and 70% believe it to be a serious problem. Only 7% of Arkansans believe too much money is currently being spent on treatment (Addiction Treatment and Long Term Recovery in Arkansas: Just Say Yes; 12). Rationale for strategies recommended by the Legislative Task Force on Substance Abuse Treatment Services follows:

(1) Seek new funding resources to expand treatment capacity and fund Medicaid. Support Drug Courts.

During the 2009 legislative session, funding for expanding the Medicaid program to provide substance abuse treatment for pregnant and post-partum women and adolescents was secured through enactment of an additional tax on tobacco products. However, due to tight revenue in the following year, none of that funding has been utilized for these program areas. Arkansas continues to leave three federal dollars on the table for every single state dollar not utilized to provide this expansion of services. During this interim of implementation of health care reform, where Medicaid will cover all those at or below 133% of federal poverty level (FPL) and subsidized insurance coverage will be provided for those below 400% of FPL, the state should seize the opportunity to implement this stop gap measure as a strategic strike to reduce costs of health care in the future. Health Care Reform (HCR) parity for substance abuse will make more treatment available for those below 400% of FPL. The state should take this step forward in providing this interim coverage for pregnant women, postpartum women and adolescents now in anticipation of full implementation of HCR in 2014.

Drug court programs save the state millions of dollars in incarceration costs while restoring families. The state should work to provide an adult drug court program in every county and increase the number of juvenile drug courts, DWI courts, veterans treatment courts and other similar therapeutic diversion programs in the criminal justice system.

(2) Continue Accountability and Quality Improvements

Require Department of Human Services, Division of Behavioral Health Services (DHS/DBHS), Office of Alcohol and Drug Abuse Prevention and its network of funded treatment providers to develop a set of performance measures using evidence-based practices. Collect and report data to treatment providers on the set of performance measures. After one year, begin development of a set of state performance standards of treatment. Empower the Alcohol and Drug Abuse Coordinating Committee to monitor, evaluate and continuously update these standards to assure accountability and quality.

The Committee is pleased with the progress being made by DBHS and treatment providers to incorporate evidence-based practices into their programs. The work should continue with the development of mutually agreed upon performance measures that will provide meaningful information to providers and policy makers in funding programs in the future.

(3) Support a Treatment Continuum of Care

The state needs to support, through funding, regulation, oversight, and otherwise, efforts to increase the availability of housing, job placement, peer-based recovery support, education and other social supports to assure that those leaving treatment have a safe, sober setting in which to continue their sobriety. The failure to provide such results in the revolving door of those continually entering the most expensive treatment, residential care, only to re-enter the same situation that resulted in their misuse of alcohol or other drugs upon release.

(4) Revised Involuntary Commitment Laws Related to Substance Abuse

In order to provide appropriate treatment in the least restrictive environment, the statute should be amended to require individuals being committed for substance abuse to have an assessment by a qualified addiction professional (see Appendix E) prior to a hearing on the commitment. The court should determine the commitment based on the assessment provided by the treatment counselor. Treatment facilities should be allowed to refuse a commitment if an assessment has not been conducted pursuant to the statute. Treatment providers will assess the person's ability to pay for treatment costs. Every effort should be made to provide the treatment facility with all necessary prescription drugs the individual has been taking under a doctor's order at the time of entry into the treatment program. The treatment provider should be allowed to discharge the individual at any time that the behavior of the individual violates the rules of the treatment provider or threatens the safety of other residents in the program. Persons should only be eligible for commitment under the statute once during a 12 month period. Persons whose names are currently listed on a waiting list of the provider should not be committed using the involuntary commitment law.

(5) Support Advocacy

Continue a statewide advocacy and communications campaign to inform policymakers and the public that substance abuse is a chronic health problem that is treatable. Reinforce, with data driven treatment information, utilization of evidenced-based practices as an effective return on investment.

Coordinated, common messages from multiple sources should be created to inform the public and various constituencies of the health problem of addiction, how treatment is effective, the family and financial impact of shortfalls in treatment, and ways that savings can be afforded to multiple systems through effective, coordinated systems of care.

CONCLUSION

Treatment works. It is the right thing to do. Arkansas must get on with the business of providing such. The set of recommendations build upon those provided in the September 2008 report while recognizing the changing landscape on the journey to implementation of health care reform. The report offers some opportunities to begin positioning the state to better utilize the limited resources available. Through leadership, support, and the ever enduring will of the strong people of Arkansas, we can build a better community in this state for this large segment of our population that will lead them to a pathway of improved health and happiness. No one deserves less.

APPENDIX A. Acronyms Relevant to the Legislative Task Force on Substance Abuse Treatment Services

AOD	Alcohol and Other Drugs
ATR	Access to Recovery
CATG	Closing the Addiction Treatment GAP
DASEP	Drug and Alcohol Safety Education Program
DBHS	Division of Behavioral Health Services
DCC	Department of Community Corrections
DCFS	Division of Children and Family Services
DHS	Department of Human Services
DOC	Department of Corrections
DDS	Division of Developmental Disabilities Services
DWI	Driving While Intoxicated
DYS	Division of Youth Services
HCR	Health Care Reform
NOMS	National Outcome Measures
NREPP	National Registry of Evidence-based Program and Practices
NSDUH	National Survey on Drug Use and Health
OADAP	Office of Alcohol and Drug Abuse Prevention
OH	Oxford House
OSI	Open Society Institute
SAMHSA	Substance Abuse and Mental Health Services Administration

APPENDIX B. REFERENCES

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APPENDIX C. PRESENTERS

PRESENTER	AGENCY
Tammy Alexander, PhD.	Assistant Director, Adult Mental Health Services, Division of Behavioral Health Services, Department of Human Services
Teresa Belew	Media & Public Policy Liaison, MADD, Arkansas Office
Jay Bradford	Commissioner, Arkansas Department of Insurance
Jim Clark	President, Substance Abuse Treatment Providers Association; Director, Health Resources of Arkansas/Wilbur D. Mills Center
Cindy Crone	Director, Family Treatment Consultation
Garland (Sonny) Ferguson	Director, Treatment Services, Office of Alcohol & Drug Prevention, Department of Human Services
David Eberhard	Director, Department of Community Correction
Victor Fitz	Current Member & Former Chair, Oxford House World Council
Janie Huddleston	Deputy Director, Department of Human Services
Jeff Hunt	Outreach Worker, Oklahoma Oxford House
Mike Linville	President, Outreach Worker, Arkansas Oxford House
Paul Meason	Director, South Arkansas Substance Abuse Program
Senator Bill Pritchard	Chair, Task Force on Substance Abuse Treatment Services
Carol Roddy	State Drug Court Coordinator, Administrative Office of the Courts
Terrell Rose	Director, Drug & Alcohol Safety Education Program (DASEP), Behavioral Health Services Division, Department of Human Services
Max Snowden	Executive Director, Arkansas Commission on Child Abuse/Rape/Domestic Violence, UAMS
Representative Tim Summers	Executive Director, Decision Point
Scott Swanson	Entrepreneurship Program Manager, North Arkansas College
Darla Tate	Director, Northeast Arkansas Recovery Center
Dr. Joe Thompson	Surgeon General of Arkansas
Dawn Zekis	Director of Policy and Planning, Department of Human Services

APPENDIX D: Qualified Addiction Professionals

Qualified Addiction Professionals:

Licensed Alcoholism and Drug Abuse Counselor (LADAC)

Licensed Associate Alcoholism and Drug Abuse Counselor (LAADAC)

Advanced Alcohol and Drug Counselor (AADC)

Certified Alcohol and Drug Counselor (CADC)

Certified Co-occurring Disorders Professional – Diplomat (CCDP-D)

Certified Co-occurring Disorders Professional – Bachelor (CCDP-B)

Certified Co-occurring Disorders Professional – Associate (CCDP-A)

* Persons holding mental health professional license who have an official licensing board approved scope of practice that specifically endorses addiction treatment.